MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2303

2007 SENATE HUMAN SERVICES

SB 2303

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2303

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 1-23-07

Recorder Job Number: 1641,1714

Committee Clerk Signature Mary K Monson

Minutes:

Senator J. Lee, Chairman, opened the hearing on SB 2303 relating to creation of a health information technology steering committee; and to provide an appropriation.

Senator J. Lee (Dist. 13) introduced SB 2303 and said it is an exciting next step in what has been ongoing for the last two years. There has been an emphasis on how important technology is going to be. She encouraged the committee to look at this health information technology opportunity. They are also looking at the possibility of providing some funding to assist some locations with getting going.

Senator Erbele asked if there were any questions.

Senator Dever asked if there were supposed to be any legislators on the list.

Senator J. Lee said the committee could discuss that in further detail. She also had a message from the nursing association that they would like to be considered as an addition to the list. (Attachment #1)

Lynette Dickson (Project Director, Center for Rural Health) provided testimony and recommended revisions for SB 2303. (Attachment #2)

Dave Peske (ND Medical Association) served on the task force and wanted to say they support the efforts this bill is trying to achieve. He pointed out that there are many large

systems in North Dakota that have, on their own, started and implemented for quite some time health information technology. There are also many other smaller health care facilities that see the need to move along in this process.

There was no opposing testimony.

Senator J. Lee called for neutral testimony.

Arlan Thomas (President of ND Health Care Association) said they are reviewing SB 2303 and haven't taken a position with respect to what it means or its implications and/or source of funding. He would be happy to report back to the committee after they have had an opportunity to discuss SB 2303. He brought to the committee's attention that 1274 was heard in the House recently. That is a capital bill and would allow up to $400,000 to be used for addressing some of the capital needs hospitals and others are facing with respect to technologies and limited capital purchases. He wasn't sure how that will coordinate with 2303. With respect to IT and health information technology in general, this is a big issue. (Meter 17:35) He asked if he could report back to the committee.

Senator J. Lee said any help they could give the committee as soon as possible would be greatly appreciated.

(Meter 21:50)There was some discussion on funding through the National Governor's Association. No money trickled down for the states.

The hearing on SB 2303 was closed.

Job #1714

Senator J. Lee brought up a point, which she thought was valuable, that Chip Thomas made. He asked about the existing health council and if we are looking at any kind duplication. She didn't think they were but, if they are, they need to think about that. She pointed out that the task force organized themselves and they moved forward with a fair amount of work on this.

She felt it was important that they not create another level of bureaucracy. She encouraged the committee to visit with health care providers in their districts to see where they are with this. There are some small communities moving together quickly to do a sharing of information software program and other smaller facilities nearby can buy into that. (Meter 1:53)

Senator J. Lee was also interested in knowing what MN is doing with this.

Senator Erbele asked if this would be a program where the appropriation would continue to grow.

Senator J. Lee said that possibility exists and that is why they have to be careful whether they feed it in the first place.

(Meter 4:50) There was discussion on the potential for working with other states.

Discussion on SB 2303 was closed.

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2303

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 1-30-07

Recorder Job Number: 2333

Committee Clerk Signature Mary K Mason

Minutes:

Senator J. Lee, Chairman, opened SB 2303 for discussion and provided the committee with a list of questions from Chip Thomas. (Attachment #3)

Senator Warner asked if this is granting authority or is this just to cover the expenses of the committee.

Senator J. Lee replied it is supposed to be providing funds that could be given to small health care providers to implement technology.

Senator J. Lee reported that she had inquired about where the state health council fits in. She said they had agreed to pass off to this HIT group any of the technology related questions because this group is the one with the expertise.

Senator J. Lee asked Richard Brown if he had information to offer.

Mr. Brown (Meter 3:20) didn't think the big communities would have any problem getting on board with this but the rural communities could be having a very hard time getting up to speed on this.

Senator J. Lee (Meter 4:30) said language for this was given to her by the health information steering committee. She wants ND to be on board with this and the rural area is an important issue because they don't have the money to implement this. The idea of the appropriation was

not only to put the steering committee in place but also to have money available that maybe the rural areas could apply for to get started with this.

(Meter 7:40) There was discussion on proposed amendments. They focused on the amendment submitted by Lynette Dickson.

Senator Erbele moved to adopt the Dickson amendment. Senator Warner seconded the motion. Roll call vote 6-0-0. Amendment accepted.

Senator Warner moved a Do Pass as amended and rerefer to Appropriations.

The motion was seconded by Senator Pomeroy.

(Meter 15:11) Discussion followed on the comments by Chip Thomas, specifically number 11. Also they discussed that there didn't seem to be a plan in place for the $500,000. The steering committee wanted it for grants. The committee talked about reducing that amount of appropriation and instructing them to put a plan in place.

Senator Warner withdrew his motion and Senator Pomeroy withdrew his second. Carried by a voice vote 6-0-0.

Senator Erbele moved to further amend to cut the appropriation to $100,000.

Motion seconded by Senator Dever.

Roll call vote 6-0-0. Amendment accepted.

Senator Erbele moved a Do Pass as amended and rerefer to Appropriations.

Senator Heckaman seconded the motion.

Roll call vote 6-0-0. Motion carried. Carrier is Senator Pomeroy.

FISCAL NOTE

Requested by Legislative Council
03/09/2007

Amendment to: Engrossed SB 2303

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2005-2007 Biennium		2007-2009 Biennium		2009-2011 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures			$85,000		$85,000	
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2005-2007 Biennium			2007-2009 Biennium			2009-2011 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill creates a health information technology steering committee which will make recommendations for implementing a statewide health information infrastructure consistent with emerging national standards.

The amendment to this bill removes $100,000 of general fund appropriation.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

In Section 1.2, it states that the Department of Health is to provide administrative services to assist the steering committee. In Section 1.3, it states that the steering committee is to develop a grant program to assist in the planning and implementation of health technology projects. Since the appropriation to this bill has been removed, it will be impossible to carryout these activities.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Section 1.2 indicates the Department of Health is to provide administrative services to assist the steering committee. Section 1.3 indicates the steering committee is to develop a grant program to assist in the planning and implementation of health technology projects. The bill is unclear as to where the grants administration program would be housed. If the Department of Health is to be responsible for administrating the grants program, and providing administrative services to the steering committee we would need $85,000 of general funds for an HSPA IV (.5 FTE), including $19,000 for operating expenses.
Since there are not dollars available to fund this program, we suggest the language in Section 1.3 be removed from the bill.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a*

continuing appropriation.

The fiscal impact of this bill is not included in the Department of Health's appropriation bill (HB 1004). General funds will need to be appropriated.

Name:	Kathy J. Albin	**Agency:**	Department of Health
Phone Number:	328.4542	**Date Prepared:**	03/09/2007

Date: 1-30-07
Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2303

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Adopt Dickron amendments

Motion Made By Sen. Erbele Seconded By Sen. Warner

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 1-30-07
Roll Call Vote #: 2

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2303

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken DP as amended / approp.

Motion Made By Sen. Warner Seconded By Sen. Pomeroy

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman			Senator Joan Heckaman		
Senator Robert Erbele, V. Chair			Senator Jim Pomeroy		
Senator Dick Dever			Senator John M. Warner		

Motion withdrawn by voice vote 6-0-0

Total (Yes) No

Absent

Floor Assignment ~~Senator~~

If the vote is on an amendment, briefly indicate intent:

Date: 1-30-07

Roll Call Vote #: 3

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2303

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Change approp. to $100,000

Motion Made By Sen. Erbele Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner	✓	

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 1-30

Roll Call Vote #: 4

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2303

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 70468.0201 Title .0300

Action Taken DP / amended / approp

Motion Made By Sen. Erbele Seconded By Sen. Heckaman

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator Pomeroy

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2303: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2303 was placed on the Sixth order on the calendar.

Page 1, line 7, after "information" insert "technology"

Page 1, line 8, after "information" insert "technology"

Page 1, line 15, replace "communities" with "and urban economic development entities"

Page 1, remove line 17

Page 1, line 18, replace "e." with "d."

Page 1, line 19, replace "f." with "e."

Page 1, remove line 20

Page 1, line 21, replace "h." with "f." and replace "physicians" with "and urban health care providers"

Page 1, line 22, replace "i." with "g."

Page 1, line 23, replace "j." with "h."

Page 1, line 24, replace "k." with "i."

Page 2, line 1, replace "l." with "j."

Page 2, line 2, replace "m." with "k."

Page 2, line 3, replace "n." with "l."

Page 2, line 12, after "standards" insert ", promotes the adoption and use of electronic health records and other health information technologies,"

Page 2, line 15, replace "that will fund collaborative" with "to assist in the planning and implementation of"

Page 2, remove line 16

Page 2, line 17, remove "health information technology systems"

Page 2, line 22, replace "$500,000" with "$100,000"

Renumber accordingly

2007 SENATE APPROPRIATIONS

SB 2303

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2303

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 02/06/07

Recorder Job Number: 2946

Committee Clerk Signature

Minutes:

Chairman Holmberg opened the hearing on SB 2303.

Senator Judy Lee, District 13, West Fargo, testified in support of SB 2303 which provides for the improvement of the electronic health records. She indicated a facet of providers do not have the resources to do this on their own. She continued to encourage support of the bill and to restore the original funding.

Senator Holmberg emphasized the message on line 15-18 on page 2 of the original bill.

Senator Mathern indicated he support this effort but wondered if the Nurses Association should be on the committtee.

Craig Hewitt, Chief Information Officer for MeritCare Health System, presented written testimony (2) and testified in support of SB 2303. He discussed how the cost of electronic health software, infrastructure, and support differ in smaller facilities. He indicated SB 2303 would provide a grant program to provide seed funding for smaller facilities. In addition he provided a listing of the ND Health Information Technology Steering Committee Members (3), and a document showing the key activities in health information technology and health information exchange.

Several questions were raised, would small hospitals benefit more from direct grants then from this fund, if this is all technology with records of individual patients or is it directed at physicians contacting doctors in other communities, is this a duplication of systems out there, are pharmaceuticals part of the package.

Doug Kjos, programmer/analyst and EHR implementation advisor at ND Health Care Review, presented written testimony (5) and testified in support of SB 2303. He discussed a survey on electronic health records that was conducted among 50 hospitals and 308 clinics with 50 % response rate. He also felt it is essential to the grant part of the bill to have the funding restored.

Discussion ensued about the electronic sharing of records, whether this would be a duplication of efforts, whether this bill would be enough to get the job done, whether this request was made to the health department to be included in their budget, where Doug Kjos office is located and what programming language is used.

Ray Gruby, CEO, Gruby Technologies, Bismarck, provided written testimony (6) and testified in support of SB 2303 stressing how beneficial the implementation of this bill would be to the medical care in reducing the cost.

Lynette Dickson, Project Director, Center for Rural Health, UND, presented written testimony (7) and testified in support of SB 2303. She discussed other areas and the funding they have in developing programming.

Questions were raised about how many hospitals are on-line with this, is this funding the only amount that will be needed or will additional funds be needed each biennium.

Chairman Holmberg closed the hearing on SB 2303.

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2303

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 02/08/07

Recorder Job Number: 3098

Committee Clerk Signature

Minutes:

Chairman Holmberg opened the hearing on SB 2303.

Senator Mathern discussed the proposed amendments to SB 2303.

Senator Mathern moved a DO pass on the amendments. Senator Krauter seconded. Discussion followed. An oral and show of hands vote was taken resulting in 7 for 7 against. The vote ended in a tie and did not pass.

Senator Grindberg moved a DO PASS on SB 2303, Senator Christmann seconded. A roll call vote was taken resulting in 13 yes, 1 no, 0 absent. The motion carried and Senator Pomeroy will carry the bill.

Chairman Holmberg closed the hearing on SB 2303.

Date: 2/8/07
Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2303

Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken _____

Motion Made By _____ Seconded By _____

Senators	Yes	No	Senators	Yes	No
Senator Ray Holmberg, Chrm	✓		Senator Aaron Krauter	✓	
Senator Bill Bowman, V Chrm	✓		Senator Elroy N. Lindaas	✓	
Senator Tony Grindberg, V Chrm	✓		Senator Tim Mathern	✓	
Senator Randel Christmann	✓		Senator Larry J. Robinson	✓	
Senator Tom Fischer	✓		Senator Tom Seymour	✓	
Senator Ralph L. Kilzer	✓		Senator Harvey Tallackson	✓	
Senator Karen K. Krebsbach		✓			
Senator Rich Wardner	✓				

Total (Yes) 13 No 1

Absent 0

Floor Assignment Pomeroy Hum Serv

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2303: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (13 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). SB 2303 was placed on the Eleventh order on the calendar.

2007 HOUSE HUMAN SERVICES

SB 2303

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2303

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 6, 2007

Recorder Job Number: 4421

Committee Clerk Signature Judy Schock

Minutes:

Chairman Price: We will open the hearing on SB 2303.

Senator Judy Lee, District 13 W. Fargo: Health technician has become more and more important. There is a group of people already working on this through out the state trying to bring ND up to speed. It turns out there are other opportunities in other states that have already begun. Health providers in our state are looking at staging information about patients, that it would be compatible electronic format. State could turn from one provider to another to transmit information. Most do not have the funds to develop there own network or central data base. This would enhance health care in ND.

Craig Hewitt, chief information office for MeritCare Health system: See attached testimony, community members to HIT, and summary health information.

Representative Porter: In the discussion of the hearing committee has there been any discussion in tying into and enhancing MMIS project that we are spending 60 million dollars on in the Department of Human Services. The discussions we have been having in regards to MMIS it certainly be the back bone of what you are talking about so that there would not have to be a duplication in a lot of the areas. To me it would be less time spent in doing this in reverse, rather than a stand alone committee.

Mr. Hewitt: There has not been direct discussions, essentially they are components and you build these roads together, so Medicaid systems would hook into this. The Medicaid system is dealing with the back end reimbursement component. It is really not getting in the in depth component (could not understand). It is monitoring the patient, vitals, labs and pharmaceutical, test results, and sharing information with treatment plans. That to the best of my knowledge is really not at the core of what the new Medicaid system is. They should be complimentary.

Representative Porter: From the duplication stand point. I have been involved in transporting patients to Mayo clinic from the facilities in Bismarck. We take all of the tests, charts, x-rays, and MRI's results. We arrive and they throw them in the garbage, and do them all over again. Where is the mandate if they duplicate they don't get paid?

Mr. Hewitt: This is a long term process. There is no mandate now however, I feel it will be coming up, and mandated at the federal level. It needs to be done and it will be done. Every state has to make an effort to change that.

Representative Kaldor: How does the current steering committee get formulated? Was this a voluntary come together in different groups?

Mr. Hewitt: If you look at the list of events, it basically came together with what Senator Conrad's group has put together originally. There were willing folks that were willing participants to represent their various areas on the steering group.

Rep. Kaldor: The steering committee's purpose was to develop health technology steering committee that is addressed in our legislation. So this group could be appointed by the Governor? This is a small amount of money. Was the Governors office involved, and part of the Governor's budget?

Mr. Hewitt: Yes, and yes, the Governor's budget was involved, but I am not sure about that. I think it is money well spent.

Representative Porter: BC/BS takes a high interest in duplicating services and the expense because of it. They also have a foundation in a granting procedure price. The appropriation part of 100,000, if that was to go away, has there been any contact with other foundations including BC/BS to look at it favorable.

Mr. Hewitt: BC/BS is represented on this steering committee. (Hard to hear and understand)

Chairman Price: What is this committee doing that the original committee could not accomplish?

Mr. Hewitt: I would plead for some of the initial funding which would be seed money to help the less advantage rural health care providers participate in what the vision is for ND for the use of health care and IT in being able to operate that.

Chairman Price: We get skeptical because every time someone comes in they want a consultant or a steering group or what ever and want 100,000 for that. How are you seeing this committee making a recommendation for interoperable systems and competing entity?

Mr. Hewitt: That is what I believe is the beauty of having this group together that is collaborating. They have their own stake holders that they have to answer to.

Representative Kaldor: We are looking at an IT system in Mayville hospital. We need to revamp ours, and we are working with a consortium already. How will this function or operate when the entities are already investing sums of money. Should they be waiting for a year?

Mr. Hewitt: The word should go out, if you are moving towards an initiative to purchase information Technology. At the very least you should purchase systems that have been certified by the commission.

Doug Kjois, programmer/analyst and HER implementation advisor at ND Health Care Review Inc. See attached testimony. This is designed to address and improve health care in ND.

Chairman Price: Were there any discussions of the committee on pay for performance?

Mr. Kjois: No, not discussed in committee. There are pilots across the country.

Dave Peske, with ND Medical Association: The medical association recognizes the importance of this issue. There are a lot more unanswered questions than answered. We are pleased to be a part of this bill.

Chairman Price: Do you think this will move forward with out the bill?

Mr. Peske: Yes, I think that things have to evolve. We would rather have a coordinated effort. All the stake holders involved in a thoughtful manner rather than a committee getting together to discuss this.

Dan Ulmer, with BC/BS: We support the bill. Part of the answer to your question is you have to look nationally at what is happening. There was a huge issue on electronic health records. One was with the code system and the other anti trust in terms of hospitals being able to buy this technology. Seems for us this to be a good vehicle and what we are going to do in ND. One of the issues we are looking at we would like to compliment this particular bill or group if you will by moving forward with these types of grants. This is big thinking stuff.

Lynette Dickson, Project Director at the Center of Rural Health, University of ND: See attached testimony along with activities of the past year.

Chairman Price: I have a couple questions on the bill. State Health officer, it doesn't say designee is that something we want in there? It doesn't say designee as it does for the other two. Is there any consideration for legislators, in process or already on national health

information technology committee? Do you have a capped number? How many people as stake holders and contracts get travel dollars?

Ms Dickson: We have talked about that. That is part of our support and input to what the committee has now going forward, and others. We know having that input could be very beneficial. We have a stake holders group and we could have legislators. We have not come up with a cap at this time. We are attempting to keep it manageable. If someone can't afford to travel to a conference we would be able to give them minimal dollars.

Terry Dwelle, State Health Officer with the ND Department of Health. See attached testimony information with strategy and state map. One question was raised, why was this was not in the Governor's budget? It was a matter of timing. We submitted out budget back in July.

Chairman Price: Anyone else in favor of SB 2303? Any opposition? If not we will close the haring on SB 2303

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2303

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 7, 2007

Recorder Job Number: 4601

Committee Clerk Signature Judy Schock

Minutes:

Rep. Porter I think that they are definitely moving in the right direction in what they are trying to do. I also think that there is plenty of outside assistance out there that will get them where they want to go. Inside of this bill talks about accepting outstanding contributions, gifts, and grants. I guess at this point of time I don't really see a need for the appropriation section. The rest of the bill certainly has its merit. I would move that we amend on page 2 lines 19, 20, 21, 22, 23 out of the bill.

Rep. Price: Do you think they will want to be a committee without any money?

Rep. Porter: Well I know that for a fact that Blue Cross Blue Shields foundation and the Dakota Foundation are all interested in these types of projects. If they go out and do a little work they certainly will have the money to start looking at some of these systems to bring them together. Plus on top of that the whole MMIS thing is an unanswered part of that. I think they have a purpose and they have a committee who has the ability to go out and raise funds. That is a good start. If they truly come together with some kind of project then the next legislative assembly can deal with that. They can say that now we have found a way to do this and get to the electronic era here is what we need for the demonstration process.

Rep. Price: Is your amendment going to add 'or designee' on line 10?

Rep. Porter: No, I missed that part of the testimony.

Rep. Price: We have a motion, do we have a second?

Rep. Conrad: I second that. Did I understand that this money would go to make it possible for rural hospitals to participate if that is the reason for the money?

Rep. Price: That is what would happen.

Rep. Conrad: So the committee and their staff? To me it doesn't necessarily cost $100,000.

Rep. Price: They are for the tobacco funds. Every time we pass something through here they want me to that involve their committee it is $100,000. I don't think the $100,00 will give you much of a grasp to go out.

Rep. Conrad: I thought it would be to participate?

Rep. Price: No it's not to participate. They are talking half of a million. That gives them more grants to start technology projects.

Rep. Hatlestad: Does this section mandate a need to make it different from the one that they already have?

Rep. Price: Yes.

Rep. Hatlestad: So if we already have the committee existing, do we need the bill at all since we took the money out?

Rep. Porter: Really the only thing that it would say is that the ability for the committee to accept the contributions is not going to exist. The existing one and this will merge into this one because this one now can accept money and expend money as it is granted to them. This one also sets up in the law what their function is as far as getting a statewide network in the structure. I think what will happen is the other one will go away and this one will become the committee because this can accept the grants. That is really the only difference I see.

Rep. Potter: The motion that is on the floor is to take the $100,000 appropriation out and leave the rest of the bill as is?

Rep. Price: Yes. And add 'or designee'. All in favor say 'aye' all opposed say 'no'. The motion is carried.

Rep. Porter: I don't think that language is going to hurt anything being in there. If they do get a grant to do that then they have the authorization to do so. I don't see that it is a problem. The Code of Foundations says that if it wants to go to a demonstration project then they have the ability to do that.

Rep. Porter: I move a do pass as amended.

Rep. Hatlestad: I second that.

Rep. Price: There is a motion for a do pass as amended on SB 2303. Is there any discussion? If not we will take the roll call. The do pass as amended motion passes with a vote of 11-1-0. Who will carry this bill?

Rep. Pietsch: I will.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2303

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 12, 2007

Recorder Job Number: 4935 (beginning at 85:50 on the tape)

Committee Clerk Signature Sherry Clark

Minutes:

Vice Chairperson Pietsch said they pulled SB 2303 off the calendar today. She asked the committee to pull SB 2303 from their file. We amended this bill. It is relating to the creation of the health information technology steering committee. They wanted one hundred thousand or so much of the money for defraying the costs. We amended that to say that it looks like they are doing ok with the stake holders. We hope that you will keep investing and go ahead and do it but we are not going to put any state money in it. It was well and good when we accepted the amendment on Friday and it was approved and then the Health Department said wait a minute. Since you took out the hundred thousand dollars we need to put in a fiscal note. They now have a fiscal note. Apparently Judy did not get copies so I will have them get copies for us. Now they are saying that if there will be an eighty five thousand dollar expenditure that they would like out of the general fund. It indicates that the Department of Health is to provide administrative services to assist the steering committee and indicating that the steering committee is to dissolve the grant program to assist in the planning and implementation of the health technology projects. If the Department of Health is to be responsible for administrating the grants programs then they would need eighty five thousand

dollars of general funds to do that. That also includes nineteen thousand dollars for operating expenses so it is not all salaries.

Representative Porter said when we did the amendment to remove the appropriation apparently we are working it in the right direction. On page 2, lines 6 & 7 maybe we should, as we look at this, just cross off that the state will provide the administrative services and let them continue functioning the way they are and then we will see what the fiscal notes changes. He made the motion to reconsider the actions.

Representative Conrad seconded the motion.

Chairman Price took over the meeting. She called for a voice vote. The motion carried. She said as we go forward with this bill, maybe it just needs to die.

Representative Porter made a motion for a **do not pass on SB 2303.**

Representative Hatlestad seconded the motion.

Chairman Price asked for discussion. Hearing none, the clerk called the roll for a do not pass on SB 2303. Let the record show 10 yes, 2 no with all present.

Representative Pietsch will carry this bill to the floor.

Date: 3/7
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES S.B. 2303 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Move Amendments

Motion Made By Rep. Porter Seconded By Rep. Weisz

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman			Kari L Conrad		✓
Vonnie Pietsch – Vice Chairman			Lee Kaldor		
Chuck Damschen			Louise Potter		✓
Patrick R. Hatlestad			Jasper Schneider		
Curt Hofstad					
Todd Porter					
Gerry Uglem					
Robin Weisz					

Total (Yes) 9 No 2

Absent 1

Floor Assignment Rep.

If the vote is on an amendment, briefly indicate intent:

Date: 3/1
Roll Call Vote #: 2

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES SB 2303 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do pass as amended

Motion Made By Rep. Porter Seconded By Rep. Hatlestad

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman		✓	Kari L Conrad	✓	
Vonnie Pietsch – Vice Chairman	✓		Lee Kaldor	✓	
Chuck Damschen	✓		Louise Potter	✓	
Patrick R. Hatlestad	✓		Jasper Schneider	✓	
Curt Hofstad	✓				
Todd Porter	✓				
Gerry Uglem	✓				
Robin Weisz	✓				

Total (Yes) 11 No 1

Absent 0

Floor Assignment Rep. Pietsch

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2303, as engrossed: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (11 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). Engrossed SB 2303 was placed on the Sixth order on the calendar.

Page 1, line 2, remove "; and"

Page 1, line 3, remove "to provide an appropriation"

Page 1, line 9, after "officer" insert "or the state health officer's designee"

Page 2, remove lines 19 through 23

Renumber accordingly

Date: 3/12
Roll Call Vote #:

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES S.B. 2303 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken motion reconsider action

Motion Made By Rep. Porter Seconded By Rep. Conrad

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman			Kari L Conrad		
Vonnie Pietsch – Vice Chairman			Lee Kaldor		
Chuck Damschen			Louise Potter		
Patrick R. Hatlestad			Jasper Schneider		
Curt Hofstad					
Todd Porter					
Gerry Uglem					
Robin Weisz					

Total (Yes) 12 "Click here to type Yes Vote" No 0 "Click here to type No Vote"

Absent 0

Floor Assignment Rep.

If the vote is on an amendment, briefly indicate intent:

Date: 3/12
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES SB 2303 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Move Do not Pass

Motion Made By Rep. Porter Seconded By Rep. Hatlestad

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman	✓		Kari L Conrad	✓	
Vonnie Pietsch – Vice Chairman	✓		Lee Kaldor	✓	
Chuck Damschen	✓		Louise Potter		✓
Patrick R. Hatlestad	✓		Jasper Schneider		✓
Curt Hofstad	✓				
Todd Porter	✓				
Gerry Uglem	✓				
Robin Weisz	✓				

Total (Yes) "Click here to type Yes Vote" 10 No "Click here to type No Vote" 2

Absent 0

Floor Assignment Rep. Pietsch

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2303, as engrossed and amended: Human Services Committee (Rep. Price, Chairman) recommends **DO NOT PASS** (10 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2303, as amended, was placed on the Fourteenth order on the calendar.

2007 TESTIMONY

SB 2303

NDLA, S HMS

From: Lee, Judy E.
Sent: Tuesday, January 23, 2007 8:41 AM
To: NDLA, S HMS (shms@nd.gov)
Subject: FW: SB2303 Information Technology Committee

Mary - Please help me remember to add this information to our file on 2303.

From: Wanda and Louis [mailto:justducky@bis.midco.net]
Sent: Tuesday, January 23, 2007 6:47 AM
To: Lee, Judy E.
Subject: SB2303 Information Technology Committee

Dear Senator Lee,

SB2303 Relating to the creation of a health information technology steering committee is being heard in your Human Services Committee.

In reviewing the bill it became evident that nursing was not listed as one of the possible steering committee members.

In North Dakota there is a number of nurses who have a graduate degree in nursing Informatics. Nursing informatics is a combination of computer science, information science and nursing science designed to assist in the management and processing of data information and knowledge to support patients, nurses and other providers in their decision-making in all roles and settings. These nurses would be a asset on a health information technology steering committee.

Please consider the following amendment offered by the North Dakota Nurses Association (NDNA).

Amend Section One of SB2303 by adding o. North Dakota nurses association to the list of steering committee members.

I will not be able to attend the committee meeting due to a conflict with class but can be reached by phone at 323-6274 or you can contact at the following e-mail address wrose@mohs.org

Thank You for your consideration,

Wanda Rose RN
North Dakota Nurses Association
Lobbyist

Attachment #2

Senate Human Services Committee Hearings

Tuesday, January 23, 2007

Good morning Madam Chair and members of the Senate Human Services Committee. Thank you for this opportunity to speak in support of and recommend revisions to Senate Bill No. 2303 introduced by Senator Lee and Representative Price.

My name is Lynette Dickson; I am a Project Director at the Center for Rural Health, University of North Dakota and have been serving as the coordinator for the "ND Health Information Technology (HIT) Steering Committee".

Before I comment on recommended revisions, I would like to provide you with some background. In April, 2005 the first **ND HIT Summit** was held. Based on information presented at the Summit, it was clear that numerous states are moving forward with statewide HIT initiatives in order to increase the efficiency of health care being delivered as well as to improve quality of care. According to the Institute of Medicine of the National Academies, information and communication technology is a powerful tool to help transform the American health system to the more desirable mode of care which is patient centered. To ensure that North Dakota not lose ground, a group of individuals formed the **ND HIT Steering Committee**. The eighteen committee members represent a spectrum of stakeholders who recognize the urgency and share a commitment to helping our state develop, adopt, and use technology to improve the quality, safety and efficiency of health care for North Dakota residents. A list of the Steering Committee members is included with the documents provided.

The federal government has provided significant leadership in advancing the HIT agenda, however there is an enormous amount of important work to be done on the state and local level. According to the 2006 Ehealth Initiatives' annual survey, 35 states are planning or have already initiated HIT efforts. Our committee has been in contact with states that have surged ahead with successful approaches, such as Minnesota, Washington, Arizona and Rhode Island, to name a few. The focus of the committee has been to familiarize ourselves with the work being done in other states in order to glean lessons which can be applied in our state. For example, once a statewide committee/task force or advisory group has been formed the next step has consistently been to conduct a statewide assessment to determine such things as: the current adoption and utilization of technology, as well as the gaps, across a range of health care entities; the readiness of health care entities to adopt technology in their facilities; the challenges for facilities; the capacity of the state infrastructure; and assessment of the state standards for information exchange. This information is then used to inform recommendations and strategies for the state to promote the adoption of technology in a thoughtful yet progressive manner. A fact sheet of Key Activities in Health Information Technology and Health Information Exchange(HIE) is included in the documents provided.

Considering the size of North Dakota we are well positioned to make real strides in this area as long as we take action now and don't fall further behind in the HIT arena. The formation of this committee is the first step toward progress. To date, this effort has occurred through the commitment of members volunteering their time in order to keep state activity moving forward. However, as with other states, we need a focused effort in our state that supports the further development of this infrastructure. Following effective strategies used in other states and in

order to get the necessary work done in North Dakota, we are requesting support for the essential work of a committee as well as funds that will support grants for collaborative HIT planning and/or implementation projects.

Without developing and implementing an active plan to incorporate Health Information Technology as part of our state's health care infrastructure, North Dakotans are at risk of being left behind as the nation moves forward with an electronic health care delivery system. Because of the efficiency, accuracy and availability of information, most of us wouldn't go to a bank that uses paper and pencil for transactions. Increasingly, we need to recognize -- as so many other states already do -- the importance of harnessing information technology for health care in the same way for many different reasons.

For example, as health care providers choose to practice in our state, the next generation will be looking for places that have all the available tools-including health information technology essential to delivering high quality, efficient care. Health care consumers will be interested in and expected to play active roles in their health decisions. Ready access to their health information will be important to that active participation. Today we have individuals and organizations in the state who are committed to helping move this information technology agenda forward in order to transform and improve the way health care is delivered. Going forward, partnership and support from the state is an essential component of this effort and this bill helps to accomplish that.

Recommended Revisions

Recognizing the critical importance of supporting the state moving forward on building health information technology infrastructure, Senator Lee drafted the bill before you. Most of our committee members submitted comments which were incorporated; however we have a few small but important additional revisions we are recommending.

Page 1 of Bill 2303

Line 7 - add technology after health information

Line 8 - add technology after health information

Line 13 - add, but not limited to: following stakeholders, which may include:

Reason – This will provide for additional committee members who might not fall in to one of the categories specified, but are key to the health information technology effort.

Line 15 - eliminate Rural Communities and replace with Rural and Urban Economic Development.

Reason - Rural Communities are represented by the various rural health care facilities, organizations and providers.

Line 17 - eliminate d. Clinics

Reason - Clinics are covered by line 14 a. Rural and Urban Health Care Facilities and Organizations.

Line 20 - eliminate g. Physicians, and replace with Rural and Urban Health Care Providers

Reason - Health care providers is inclusive of physicians and recognizes other clinicians that will be essential to the use of HIT, including pharmacists, nurse practitioners and so on.

Line 21 - eliminate h. Rural Physicians

Reason – This is covered in revised Line 20.

Page 2 of Bill 2303

Line 12 –after national standards – add, promote the adoption and use of electronic health records and other health information technologies, and change promotes to promote

Reason: Many health care facilities don't yet have technologies such as electronic health records and computerized radiography, efforts to adopt these technologies must often precede interoperability efforts.

Line 14 – eliminate, The steering committee shall develop a

Line 15, 16 - eliminate existing lines.

Line 17 – eliminate health information technology systems, and replace with, The steering committee shall develop a grant program to assist the planning and/or implementation of health information technology projects.

Reason: The adjectives "collaborative" and "interoperable" in the original description, unnecessarily constrain the type of projects that may be considered, especially for those facilities currently without electronic health records. The use of and/or seeks to make it clear that planning grants and implementation grants may exist independently.

This concludes my testimony, thank you again for this opportunity to speak in support of and recommend revisions to this bill. I would be pleased to respond to any questions.

North Dakota Health Information Technology (HIT) Steering Committee Members

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Representing rural healthcare facilities, organizations & communities

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Representing the Governor

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Representing Human Services

Key Activities in Health Information Technology (HIT) And Health Information Exchange (HIE)

December 2006

Key National Activities:

- Enactment of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
- President Bush announced his vision for the widespread adoption of interoperable electronic health records by 2014 (April 2004).
- Establishment of the Office of the National Coordinator for Health Information Technology (ONCHIT) in the federal Department of Health and Human Services (April 2004).
- The creation of the Certification Commission for Healthcare Information Technology (CCHIT) which is a voluntary, private-sector organization to certify HIT products on functionality, interoperability and security (July 2004).
- The authorization of the Commission on Systemic Interoperability by the Medicare Modernization Act. The Commission developed a strategy to make healthcare information instantly accessible at all times, by consumers and their healthcare providers (January 2005).
- The creation of the HIT Standards Panel (HITSP) which brings together public-private stakeholders to harmonize the existing information technology standards used to exchange healthcare data in the U.S.

Continued on other side

Key North Dakota Activities:

- Senator Conrad's North Dakota Health Information Technology Summit (April 2006)
- Formation of North Dakota HIT Steering Committee and Stakeholders Group (April 2006)
- North Dakota HIT Steering Committee and Stakeholder Group, one-day workshop (August 2006)
- North Dakota HIT Steering Committee Vision/Mission and Immediate Goals developed (November 2006)
- Committee reviewed HIT/HIE activities in other states (November 2006)

*For more information on the **North Dakota HIT Steering Committee** visit http://mededicine.nodak.edu/crh/sorh/hit/*

Key Trends Occurring Across the U.S.:

- **HIT planning in states is on the rise,** with 28 states initiating or in the process of planning, and an additional seven states with plans completed and implementation underway.
- **Primary focus of state policy is on creation of commissions to develop recommendations and plans for HIT.** Fifty-three bills, emerging from 25 states during 2005 and 2006, call for the creation of bodies such as commissions, councils or task forces to conduct studies, recommend actions, and develop strategies and plans for improving healthcare through HIT. Nineteen of these bills passed in 14 states.

Key Trends Occurring Across the U.S.:

- **About half of the states in the U.S. have either an executive order or a legislative mandate** in place designed to stimulate the use of HIT to improve health and healthcare.

- **The number of states providing funding support is increasing.** Fifteen bills were introduced in 11 states which call for the incorporation of financing strategies, such as loan or grant programs in the recommendations, strategies and plans authorized by the legislation, with seven bills in six states passing. Twenty-seven bills were introduced in 16 states during the same period calling for the authorization or appropriation of funding for HIT or health information exchange-related activities. Eight such bills passed in seven states and became law.

- **HIT state legislative activity is on the rise.** State legislatures are increasingly recognizing the importance of information technology in driving health and healthcare improvements, with 38 state legislatures having introduced 121 bills that specifically focus on HIT in 2005 and 2006. States are not only introducing legislation, many bills are being signed into law. During 2005 and 2006, 36 bills were passed in 24 state legislatures and signed in to law.

- **Interest in improving quality and safety, inefficiencies experienced by providers, and rising healthcare costs are the primary drivers for health information exchange (HIE) efforts.** Ninety-two percent of respondents (eHealth Initiative's 2006 third annual survey of HIE) cited "improving quality" as a significant driver of their HIE efforts, while 82 percent cited "improving safety." Additionally, 70 percent cited "inefficiencies experienced by providers who need information to support patient care" as a significant driver, while 56 percent cited "rising healthcare costs."

esource: eHealthissue Briefs, July, August and September, 2006, publications of eHealth Initiative
http://www.ehealthinitiative.org/newsletters/IssueBrief.mspx

Key National Activities, continued:

- The development of the Health Information Security and Privacy Collaboration (HISPC) which is a partnership focused on addressing variations in business policy and state laws that affect HIE.

- President Bush signed an Executive Order, promoting quality and efficient health care in federal government administered or sponsored health care programs. The Executive Order requires Federal agency compliance by January 1, 2007 (August 2006).

- Current Federal Legislation - Senate Bill 1418 and House Bill 4157, focusing on HIT, will be combined which will support the adoption, implementation and increased utilization of technology in our health care system.

Center *for* Rural Health
University of North Dakota
School of Medicine and Health Sciences

For more information, contact:
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ldickson@medicine.nodak.edu

This fact sheet can be located at
http://medicine.nodak.edu/crh/sorh/hit/resources/HIT-HIE_keyactivites.html

UND

SB 2503

STATES TURNING TO ELECTRONIC HEALTH RECORDS TO SAVE MONEY, IMPROVE QUALITY

Volume 28, Issue 484 February 5, 2007

Matthew Gever

Developing an electronic health records (EHRs) system can be enormously expensive and time-consuming. But the dividends can be even larger, according to many experts on the subject. "Health information technology has been demonstrated to save lives and reduce health costs," said **Massachusetts** Sen. Richard Moore. "If states work toward encouraging investment in health information technology, the dividends for all Americans are enormous."

Take the Veterans Health Administration (VHA). Its Veterans Health Information Systems and Technology Architecture (VistA), a central database that stores medical information on patients, saves money and improves patient care by allowing providers to securely access a patient's information at the point of care, as well to update the patient's medical history. An article in the January 2007 *Health Affairs* estimates that VistA costs $80 per patient per year—almost exactly the same amount of money saved by eliminating just one redundant lab test for one patient.

States can use the VHA's VistA as a model to create EHRs in Medicaid and other programs, according to Lynn Etheredge, a consultant to the Rapid Learning Project at George Washington University. "This is the future of health care," Etheredge said at a conference sponsored by the HMO Kaiser Permanente and The Robert Wood Johnson Foundation.

The VistA system is credited with much of the VHA's turnaround on quality. "If you go back 10 or 15 years, the VA was considered to be at the bottom rungs of American medicine," said Etheredge. Facing increased scrutiny, in the mid-1990s the VHA reorganized itself, creating the VistA system in the process. "Today...they are probably among the very best systems on over 250 measures of quality," Etheredge said. Over the course of VistA's implementation, the number of patients seen by the VHA has increased from 3 million to 5 million, while per patient costs have decreased.

States Moving Ahead

The feds are far from the only ones moving toward EHRs. By the fourth week of January 2007, legislation relating to EHRs had been introduced in 14 states. In **Florida,** H 565 directs the state to contract with a vendor to design a database of EHRs for Medicaid providers. A bill in **Hawaii** (SB 977) would fund two new academic clinical practices to provide a pipeline of family physicians. The practices must include EHRs, which the bill says are one of the "minimum critical elements necessary for...graduate medical education." **West Virginia's** HB 2177 would provide tax credits to medical providers in an amount equal to their investment in EHRs. And **California's** universal health care bill (AB 53) declares that the state will help establish EHRs that are compatible across systems.

Missouri recently passed a bill (SB 858) to create a $25 million Healthcare Technology Fund. Beginning in FY 2007, the Show Me State will use $3.4 million from the Technology Fund to develop Cyber Access, a centralized database containing the EHRs of the state's Medicaid clients.

"It is unacceptable in the 21st century that Jiffy Lube is more technologically advanced than our health-care system," said Sen. Michael R. Gibbons. "Paper kills and we must move to a system where electronic medical records and e-prescribing are common place."

CyberAccess will enable health-care providers to electronically prescribe, collect diagnosis data, review patients' medical histories, receive alerts, select appropriate medications and request drug and medical prior authorizations.

Sen. Charlie Shields noted that CyberAccess also will help state officials combat fraud by distinguishing "those who steal from the people who really need help." Currently, 700 Missouri physicians (who already own computers) are enrolled in the program. State officials expect to enroll up to 3,000 providers, including community and rural health centers.

Not All is Rosy

States that want to set up EHR systems have many hurdles to surmount. Smaller providers generally do not have the funds to develop their own networks or central databases. One way states can deal with this is to develop a central server and allow providers to link to it, said Etheredge.

States can reduce their own costs in creating the systems by using the 90 percent match that Medicaid provides for administrative costs, which includes investment in computerized technology, said Etheredge. He also pointed out that the national Medicaid Management

Information System—the automated claims processing and information retrieval system for handling all Medicaid transactions—is being restructured to produce centralized EHRs.

Patient privacy and confidentiality also can pose problems. The Health Insurance Portability and Accountability Act deals with many of these issues by, for example, providing for the use of databases without personally identifiable information and giving patients the right to exclude information from their EHRs.

Etheredge believes that states are still a few years away from fully developing comprehensive EHR systems, as many are starting from scratch and federal rules can change. Nevertheless, thanks in part to EHRs, "Medicaid could become a national leader in quality and cost-effectiveness," he said.

NCSL provides state legislators with information and technical assistance on health information technology and health information exchange through its 18-month Health Information Technology Champions (HITCh) program. For more, go to www.ncsl.org/programs/health/forum/hitch/

Contact Kala Ladenheim, program director, Forum for State Health Policy Leadership, at 202-624-3557 or Kala.Ladenheim@NCSL.org

Attachment #3

2303

1. Doesn't the authority already exist for the executive branch to create committees/task forces and their composition for specific purposes?
2. Are there negative consequences at the facility operating level if this bill fails?
3. Are there positive consequences at the facility operating level if this bill passes?
4. How will the performance of this committee be measured over the next two years?
5. Does the committee terminate at the same time as the appropriations?
6. Is this committee to coordinate with other entities operating with similar objectives, and if so, how?
7. Are recommendations to be the result of committee consensus?
8. What happens to the committee recommendations once developed?
9. Are the recommendations binding, if so, how and upon whom?
10. What relationship is there, if any, between committee recommendations and local board of directors decision making?
11. There are currently two grant programs supporting collaborative/capital efforts---HRSA (Approximately 500,000 (Federal) s) and Blue Cross Blue Shield of North Dakota (350,000-Private). Is there greater gain in creating a one-time third capital program, versus increasing the capital in either of the two existing programs?
12. Would the proposed appropriations serve a better collaborative/capital purpose if paired with federal dollars to improve provider payer rates?
13. What is the administrative overhead to support this bill?

(2)

Senate Appropriations Committee Hearings

Tuesday, February 6, 2007

Same given to Human Services

Good morning Mr. Chairman and members of the Senate appropriations committee. I appreciate the opportunity to provide my support of Senate Bill No. 2303 introduced by Senator Lee and Representative Price.

My name is Craig Hewitt and I am the Chief Information Officer for MeritCare Health System. I have had the privilege of being a member of the North Dakota Health Information Technology (HIT) Steering Committee and participating in their exciting efforts. The committee has been convened as a group of neutral party stakeholders in order to help facilitate statewide, public-private planning which encourages the adoption and use of standard HIT which promotes efficient, timely, safe and high quality healthcare in the North Dakota.

In practical terms the long term goal is to allow the sharing of medical information (laboratory, pharmacy, radiology, etc.) so that patient care is enhanced and provided in the best interest of the patient and the health care provider, regardless of whether they are in a rural or urban setting. This would allow (for example) a healthcare provider treating a patient in Rugby, Harvey or Hazen to have the appropriate access to health care information to assist in making the best decisions possible when providing that patient his or her care. Conversely that provider could also transport the same appropriate information to a larger health center for a patient who may be referred in for more specialty or acute care. The capability has excellent potential to drive out

needless waste in providing health care, such as reducing duplicate testing because you are not sure what has been done at another facility.

While this may seem like a simple goal to accomplish there are large expenditures associated with making this happen. The cost of the electronic health software and infrastructure and associated support are difficult for smaller facilities, especially in the rural setting. Cost estimates range well over $50,000 per physician which has certainly been my experience at MeritCare.

Senate Bill 2303 includes a proposed grant program which would provide seed funding for smaller facilities that can not afford the expenses of implementing information technology. Our hope is that this will help to build the heath information highway this state needs for those who most need access to health care.

Lastly I would like to reinterate that many other states have followed this path with successes. Starting with a neutral group of stakeholders and developing a vision along with a shared business plan has been proven in states such as Minnesota (e-health), Vermont, Rhode Island, Washington and Wisconsin to name of few. It is time for North Dakota to act and move forward the initiative to share health information for the betterment of our state.

(5)

Senate Appropriations Committee
Tuesday, February 6, 2007

Good morning Mr. Chairman and member of the Appropriations Committee. Thank you for the opportunity to speak in support of Senate Bill 2303.

My name is Doug Kjos; I am a programmer/analyst and EHR implementation advisor at North Dakota Health Care Review, Inc. (NDHCRI). NDHCRI does Medicaid and Medicare case review and is primarily engaged in healthcare quality improvement projects in North Dakota under contract with CMS.

One of our responsibilities at NDHCRI is to assist North Dakota healthcare facilities with Electronic Health Record (EHR) implementation. To help understand the state of healthcare information technology, we conducted separate hospital and clinic surveys in 2005. All of North Dakota's 50 hospitals, and over half of our 308 clinics responded.

Almost all physician practices (98%) have access to the Internet and more than 90% are using practice management software (PMS). Of those using PMS, 97% use it for billing, 84% use it for patient registration, and 79% use it for appointments. Less than 1/3 of practices reported using an EHR, and only 7% of practices not affiliated with a large healthcare system had an EHR.

Although 80% of the practices without EHR say they are interested in using one, cost is cited as the primary barrier. Practices are also reluctant to purchase an EHR that may not be able to communicate with other systems.

There are 13 Prospective Payment System (PPS) hospitals and 32 Critical Access Hospitals (CAH) in North Dakota. Five PPS hospitals (38%) and two Critical Access Hospitals (6%) used an EHR. PPS/CAH is essentially an urban/rural divide.

Large systems appear more capable of implementing electronic systems than smaller ones. As the pieces that comprise electronic systems are implemented within a facility, the facility tends to focus on internal issues of new workflows and getting the pieces to communicate. As internal issues are resolved, attention turns outward to efficient communication with other systems. Consequently, systems with health information technology have an interest in others acquiring it. It is important to note that hospital EHR and clinic EHR are separate pieces. Implementation of outpatient EHR can cost $50,000 per physician. Inpatient EHR is complex and expensive. Even in North Dakota's largest systems, few have implemented both. SB2303 seeks to addresses these realities in an effort to improve the healthcare of all North Dakotans.

Because it's essential to the grant component of this legislation, I strongly urge the restoration of funding for this bill to $500,000. In my work with smaller clinics working toward EHR implementation I see the critical importance of outside assistance. It's the difference between life and death.

(6)

Senate Appropriations Committee – SB 2303

Tuesday, February 6, 2007 10:15 AM

Mr. Chairman and members of the Appropriations Committee. I wish to thank you for the opportunity to speak in support of Senate Bill 2303.

My name is Raymond Gruby and I am the CEO of Gruby Technologies, located in Bismarck ND. Before my present position, I practiced orthopaedic surgery in Bismarck at the Bone and Joint Center since 1977.

I am happy to offer testimony as a physician who has faced the difficult task of assembling medical information from disparate sources in North Dakota in caring for patients. The recent advances in health information technology can be applied to medical care in reducing the appalling cost, monetary and suffering, now encountered. This can be done without hindering the technologies already existing in the present North Dakota medical facilities but actually enhance those facilities in care giving.

We do need a vision for North Dakota Health Care. As a doctor, consumer and patient I believe that the medical facility owns the data and the patient owns the information. We should strive in ND to accomplish two goals: The first is to enable the provider to easily obtain or send standard personal health information in a secure fashion; and the second would be to enable the patient to engage in his/her care electronically as a matter of choice.

The significant decrease in the cost of hardware, emerging open standards and the improving ease of gaining secure electronic access to remote areas are very positive features for rural North Dakota. Given the correct on-line tools, the large software cost may also be addressed.

The ND HIT Steering Committee could significantly assist in the planning and implementation of health information technology projects specific to North Dakota. Low cost pilot projects to securely placing standard health information online should be investigated and the best approach for the provider and patient selected.

Thank you for your interest. I would be pleased to answer any questions you may have.

(2)

Senate Appropriations Committee Hearing

Tuesday, February 6, 2007

Good morning Chairman Holmberg and members of the Senate Appropriations Committee. Thank you for this opportunity to speak in support of Senate Bill No. 2303 introduced by Senator Lee and Representative Price.

My name is Lynette Dickson; I am a Project Director at the Center for Rural Health, University of North Dakota and have been serving as the coordinator for the "ND Health Information Technology (HIT) Steering Committee".

My colleagues have shared information with regard to their area of expertise and involvement with HIT. The Steering Committee requests that you consider restoring the appropriation to $500,000 and have prepared a Proposed Budget which demonstrates a plan to utilize the full appropriation in a thoughtful and purposeful manner (Handout).

The original appropriation request of $500,000, of which $400,000 is to be applied to a grant program is a modest investment for the state and would serve as a supplement to the current BCBSND grant program or other federal grant programs. This merely offers another means of support for ND healthcare systems to build their HIT infrastructure. The need, as my colleagues demonstrated, far out ways the available funding given the number of facilities and the range of HIT applications. Administrators are tasked with ongoing searches for combined funding options that are local, state, federal and both private and public.

The HIT Steering Committee has researched a number of grant programs as models, such as the current program funded by BCBSND ($350,000), and state funded programs in Arizona (1.5 million) and Minnesota, eHealth Initiative (1.5 million). The Committee plans to develop the Request for Proposal (RFP) and evaluation process, which is critically important, for this grant program based on the successful models mentioned above.

The grant funded projects will either be used for the planning process for adopting health information technology or if a facility is further along, an implementation grant would be more appropriate to fund a specific HIT project (e.g. Computed Radiography (CR), Picture Archiving and Communication System (PACS), Laboratory Information System (LIS), Computer Physician Order Entry (CPOE), or E-Prescribing, etc.) to further develop their overall system.

Some examples of grant funded programs that are similar in scope, and funding level that we are proposing: 1) The healthcare facilities in Rolla and Bottineau received grant funds which supported a joint effort to research, analyze and select a Laboratory Information System (LIS). These facilities share equipment and supplies in an effort to maintain access to services and reduce costs. These two facilities were awarded funds for a second year, and will continue to build an electronic medical record (EMR) by implementing order communications, specifically Computerized Physician Order Entry (CPOE) in each facility. 2) Health care facilities in Garrison, Lisbon, and Park River, have each received separate grants that support the purchase of a computed radiography system, which allows images(x-rays) to be transmitted digitally to a radiologist's, 24 hours a day, 365 days a year to the larger facilities in Bismarck, Fargo and/or Grand Forks. Physicians as well as patients have final radiologist reading within hours, rather than weeks. This will not only minimize the patient's waiting

time, but the physicians will have the ability to diagnose and treat locally or transport when necessary, thereby improving efficiency and quality care.

The **average cost** to implement a full **electronic health record** for a small rural hospital is approximately **$600,000** which is cost prohibitive to most. Because of this high cost, Administrators choose to build their systems in a stepped manner, as demonstrated by the examples provided, which is more realistic and affordable. More and more, they are working together with neighboring facilities to leverage funding and share equipment when applicable.

This concludes my testimony, thank you again for this opportunity to speak in support of this Bill. I would be pleased to respond to any questions.

Proposed Budget

Senate Bill 2303 - A Bill relating to the creation of a health information technology steering committee; and to provide appropriation.

➢ **HIT Network Planning and Implementation Grants**

The Steering Committee will develop a grant program that will assist in the planning and implementation of HIT projects. The Committee has researched a number of grant programs as models, such as the BCBSND Rural Health Grant program ($350,000), Arizona Rural HIT Adoption Grant Program (1.5 million) and Minnesota, eHealth Initiative Grant Program (1.5 million).

Example:
Planning Grants - Five Grants @ $15,000
Implementation Grants - Five Grants @ $ 65,000

Estimated TOTAL – ($400,000)

Administration of grant program – Support is requested for Administration of the grant program to include: dissemination of the RFP; compilation of the submitted proposals; coordination of the review process (proposals will be reviewed by 6-8 members of the Steering Committee and/or Stakeholder Group); notification of awardees and non-awardees; fiscal management of grants; evaluation of grant projects; compilation of required reports from grantees; submittal of final report to Steering Committee.

Estimated TOTAL – ($30,000)

➢ **Meetings**

Second Annual ND HIT Summit

The committee will plan and facilitate a second statewide HIT Summit, using the April, 2006 - ND HIT Summit, as a model.

Estimated TOTAL - ($9,500)

Steering Committee, Stakeholder Group and subcommittee meetings

Support requested for facility expenses for two face-to-face meetings a year.

Estimated TOTAL – ($2,500)

➢ **Personnel**

Support requested for administrative support, to coordinate and schedule conference calls and meetings; take minutes for Steering Committee calls and meetings; update information on website; assist with the coordination of the HIT Summit and assist with the production of documents/reports.

Estimated TOTAL - ($20,000/two years)

➢ **Contractual**

Support requested to contract for services with a national consultant, who has state HIT/Health Information Exchange(HIE) initiative expertise, to facilitate the work of the Steering Committee and sub-committees (to be established) in the development of recommendations and a strategy for a statewide health information infrastructure.

Estimated TOTAL ($18,000)

Support requested to contract for services for the development of a ND HIT Environmental Scan/report (e.g. hospital, clinics, EMS, LTC, etc.). The contractor will utilize existing data; gather additional data where there are identified gaps and work with Steering Committee and subcommittees to prepare a comprehensive report.

Estimated TOTAL – ($12,000)

➢ **Travel**

Support is requested to send HIT Steering Committee members and/or representatives from subcommittees (to be established) to a national/regional HIT meeting to gain knowledge, insight and lessons learned from other state initiatives (e.g. Annual HIMMS; eHealth Initiative national meeting or regional forum; Annual Rural Network HIT conference; Regional Privacy and Security meeting). This will also allow for instate travel reimbursement for committee members who are unable to absorb the travel costs, to HIT committee meetings.

Estimated TOTAL - ($8,000)

Testimony

Senate Bill 2303

House Human Services Committee

Tuesday, March 6, 2007; 10 a.m.

North Dakota Department of Health

Good morning, Madam Chair and members of the Human Services Committee. My name is Terry Dwelle, and I am the State Health Officer with the North Dakota Department of Health. I am here today to provide information about Senate Bill 2303.

In 2006, a group of private and public sector leaders initiated a voluntary, self-funded, collaborative effort to explore innovative, statewide approaches to improving the health status of North Dakotans. This resulted in a Statewide Vision and Strategy plan. A summary of the Statewide Vision and Strategy Planning Committee's work to date, including its strategic map, is included as an attachment to this testimony.

The planning committee identified the following vision for the health-care system in North Dakota by the year 2020:

- North Dakotans will be the healthiest Americans because:
  - Our citizens – as individuals, groups and communities – embrace personal responsibility for their health and practice healthy lifestyles.
  - Systematic approaches to prevention and wellness are supported by North Dakota's culture, policies and institutions.
  - Our health-care system is structured and supported to provide access for all North Dakotans to appropriate, high-quality, patient-centered health care in response to disease and injury.

As identified on the planning committee's strategic map, one of the six major categories of goals for accomplishing this vision is to implement appropriate medical technology. In fact, health information technology was identified as one of the six major priorities to accomplish by the end of 2011. A majority of Statewide Vision and Strategy Planning Committee members are looking to the Health Information Technology Steering Committee to guide that portion of the effort rather than developing a parallel workgroup.

In conclusion, appropriate health information technology will help ensure a comprehensive and coordinated approach to improving the health of all North Dakotans.

I am happy to answer any questions you may have.

House Human Services Committee
Tuesday, March 6, 2007

Good morning Madam Chairman and members of the Human Services Committee. Thank you for the opportunity to speak in support of Senate Bill 2303.

My name is Doug Kjos; I am a programmer/analyst and EHR implementation advisor at North Dakota Health Care Review, Inc. (NDHCRI). NDHCRI does Medicaid and Medicare case review and engages in healthcare quality improvement projects in North Dakota under contract with CMS.

One of our responsibilities at NDHCRI is to assist North Dakota healthcare facilities with Electronic Health Record (EHR) implementation. To help understand the state of healthcare information technology, we conducted separate hospital and clinic surveys in 2005. All of North Dakota's 50 hospitals, and over half of our 308 clinics responded.

Almost all physician practices (98%) have access to the Internet and more than 90% are using practice management software (PMS). Of those using PMS, 97% use it for billing, 84% use it for patient registration, and 79% use it for appointments. Less than 1/3 of practices reported using an EHR, and only 7% of practices not affiliated with a large healthcare system had an EHR.

Although 80% of practices without EHR say they are interested in using one, cost is cited as the primary barrier. Practices are also reluctant to purchase an EHR that may not be able to communicate with other systems.

There are 13 Prospective Payment System (PPS) hospitals and 32 Critical Access Hospitals (CAH) in North Dakota. Five PPS hospitals (38%) and two Critical Access Hospitals (6%) used an EHR. PPS/CAH is essentially an urban/rural divide. Few of the PPS systems have both inpatient and outpatient EHRs.

Large systems appear more capable of implementing electronic systems than smaller ones. As the pieces that comprise electronic systems are implemented within a facility, the facility tends to focus on internal issues of new workflows and getting the pieces to communicate. As internal issues are resolved, attention turns outward to efficient communication with other systems. Because patients move between systems, it's in the interest of patients and systems that everyone acquires their local information technology and the means to communicate with others. SB2303 seeks to addresses these realities in an effort to improve the healthcare of all North Dakotans.

Because it's essential to the grant/pilot component of this legislation, I urge the restoration of funding for this bill to $500,000. In my work with smaller systems working toward EHR implementation I see the critical importance of outside assistance. Building electronic communication between systems will require pilot projects. Electronic networks are aptly compared to highways. It's appropriate for government to play a role in the building of electronic highways, as it has played a crucial role in development of our roadways. We might ask, "What would our highway system look like if government hadn't played a part?"

Health Information Technology Bill
SB 2303

What is the deliverable?
A roadmap/recommendations will be developed, through a collaborative effort of stakeholders, to improve the quality, patient safety and overall efficiencies of healthcare utilizing health information technology. The information gathered will be disseminated to statewide organizations/associations, local healthcare facilities and providers using multiple avenues and will be used to inform the statewide vision and strategy group for the health care system.

How the deliverable will be accomplished?
By supporting the work of a (volunteer) steering committee to comprehensively review issues surrounding the adoption of health information technology for North Dakota.
To include:

- What HIT currently exists and what is needed in North Dakota health care facilities?
- Where facilities are with regard to planning and readiness to adopt HIT?
- What existing technical assistance and funding resources (e.g. local, state, federal, public and private) are available for HIT implementation?
- What resources are necessary to meet the HIT needs in North Dakota?
- What are the state and federal laws, with regard to privacy and security, affecting the electronic exchange of health information?
- What existing HIT systems and data bases (e.g. immunization registry, drivers' license data, Medicaid beneficiaries) are available to use as pilot programs.

Educate:
The committee will utilize lessons learned from other states HIT/HIE initiatives to inform North Dakota's efforts in the development of a plan to promote the adoption and increased utilization of HIT in our state.

What is the deliverable?
Five pilot projects that will grow and expand new or existing HIT systems within healthcare facilities (e.g. hospitals, clinics, home health agencies, long term care and assisted living facilities and EMS, etc.). Each project will include an evaluation component which will solicit lessons learned and data with regard to the impact, of the adoption of the chosen technology, on the following: 1) improved efficiencies; 2) improved quality of health care delivery; 3) improved patient outcomes; 4) improved patient safety/decreased medical errors; 5) improved access to healthcare depending on the scope of work for the individual projects. The information gathered will inform health care facilities in future HIT implementation projects.

How the deliverable will be accomplished?
The Steering Committee will develop a Request for Proposal/Guidance and disseminate statewide using electronic newsletters and local newspapers. Proposals will be reviewed and awards made by a panel of eight reviewers from the Steering Committee and/or Stakeholder Group. Grantees will be required to submit interim and one final report on the progress, lessons learned and additional information on impact as indicated above.

ND HIT Steering Committee Activities – to date

April, 2006

ND HIT Summit, Bismarck *- 125 participants*
Sponsored by Senator Conrad, ND Health Care Review, ND Healthcare Association, ND Medical Association, Gruby Technologies and Center for Rural Health

August, 2006

ND HIT Stakeholder - Facilitated Meeting *– 40 participants*
Included a national overview on HIT activity and health information exchange (HIE) initiatives in other states; brainstorming sessions; further developed Steering Committee and Stakeholder Group
Sponsored by Center for Rural Health

September, 2006

eHealth Initiative HIT - National Conference
Steering Committee received invitation to send a ND representative
Sponsored by BCBSND

October, 2006

Regional Privacy and Security Meeting
Steering Committee received invitation to send three ND representatives
Sponsored by ND Dept. of Health and ND Health Information Management Association

November, 2006

ND HIT Steering Committee in-person meeting
Developed Vision and Mission statements, five immediate goals, expectations of committee members, HIT/HIE Activities Fact Sheet, and sent letter, fact sheet and member list to Governor Hoeven and state legislators

December, 2006

Senator Judy Lee and Representative Clara Sue Price sponsored SB2303
Steering Committee members provided input and feedback

Jan - Feb, 2007

Testimony was provided in support of SB 2303 by Steering Committee members

March, 2007

Steering Committee will hold second in-person meeting
Purpose will be to further develop goals and action steps to inform the direction of the Steering Committee and Stakeholder Group
Sponsored by Center for Rural Health

ND Health Information Technology Steering Committee

*The **vision** is to implement a statewide health information technology and exchange infrastructure.*

*The **mission** is to facilitate the adoption and use of health information technology and exchange to improve healthcare quality, patient safety, and overall efficiency of health care and public health services in North Dakota.*

Summary of the Statewide Vision and Strategy for the Healthcare System in North Dakota

INTRODUCTION

In the summer of 2006, a group of leaders from both the private and public sectors initiated a voluntary, self-funded collaborative effort to explore innovative, statewide approaches to improving the health status of North Dakotans. This initiative, convened by Healthy North Dakota and facilitated by TSI Consulting, Inc., focused on the development of a Vision and Strategy for the Healthcare System in North Dakota.

The following people served as the Planning Committee for the initiative:

- Robert Beattie, UND School of Medicine and Health Sciences
- Sparb Collins, North Dakota Public Employees Retirement System
- James Cooper, Medcenter One Health System
- Terry Dwelle, North Dakota Department of Health
- Steve Hamar, Mid Dakota Clinic
- Dick Hedahl, North Dakota Chamber
- Cheryl Hefta, Native American MCH Program and Spirit Lake Health Tracks
- Duane Houdek, Office of the Governor
- Rhonda Ketterling, Meritcare Health System
- Karen Larson, Community HealthCare Association of the Dakotas
- Bruce Levi, North Dakota Medical Association
- Jim Long, West River Regional Medical Center
- Dave MacIver, North Dakota Chamber
- Mike Melius, Upper Missouri District Health Unit
- Tim Mihalick, Investors Real Estate Trust
- Shelly Peterson, North Dakota Long Term Care Association
- Kurt Stoner, Bethel Lutheran Home
- David Straley, North Dakota Chamber
- Chip Thomas, North Dakota Healthcare Association
- Robert Thompson, Altru Health System
- Mike Unhjem, Blue Cross/Blue Shield of North Dakota
- Mark Weber, Golden Heart EMS
- Melissa Olson, Healthy North Dakota (convener)
- Tim Fallon, TSI Consulting, Inc (facilitator)

The Planning Committee's efforts, completed in early 2007, are summarized in this document and include the following:

- A vision for the healthcare system in North Dakota: 2020
- A strategic map which outlines key initiatives to be undertaken between 2007 and 2011
- Other priorities that need to be addressed as part of the vision and strategy

By providing a concise summary of the Planning Committee's work, this document sets the stage for engaging other stakeholders throughout North Dakota in efforts to help North Dakotans become the healthiest Americans.

VISION FOR THE HEALTHCARE SYSTEM IN NORTH DAKOTA: 2020

North Dakotans will be the healthiest Americans.

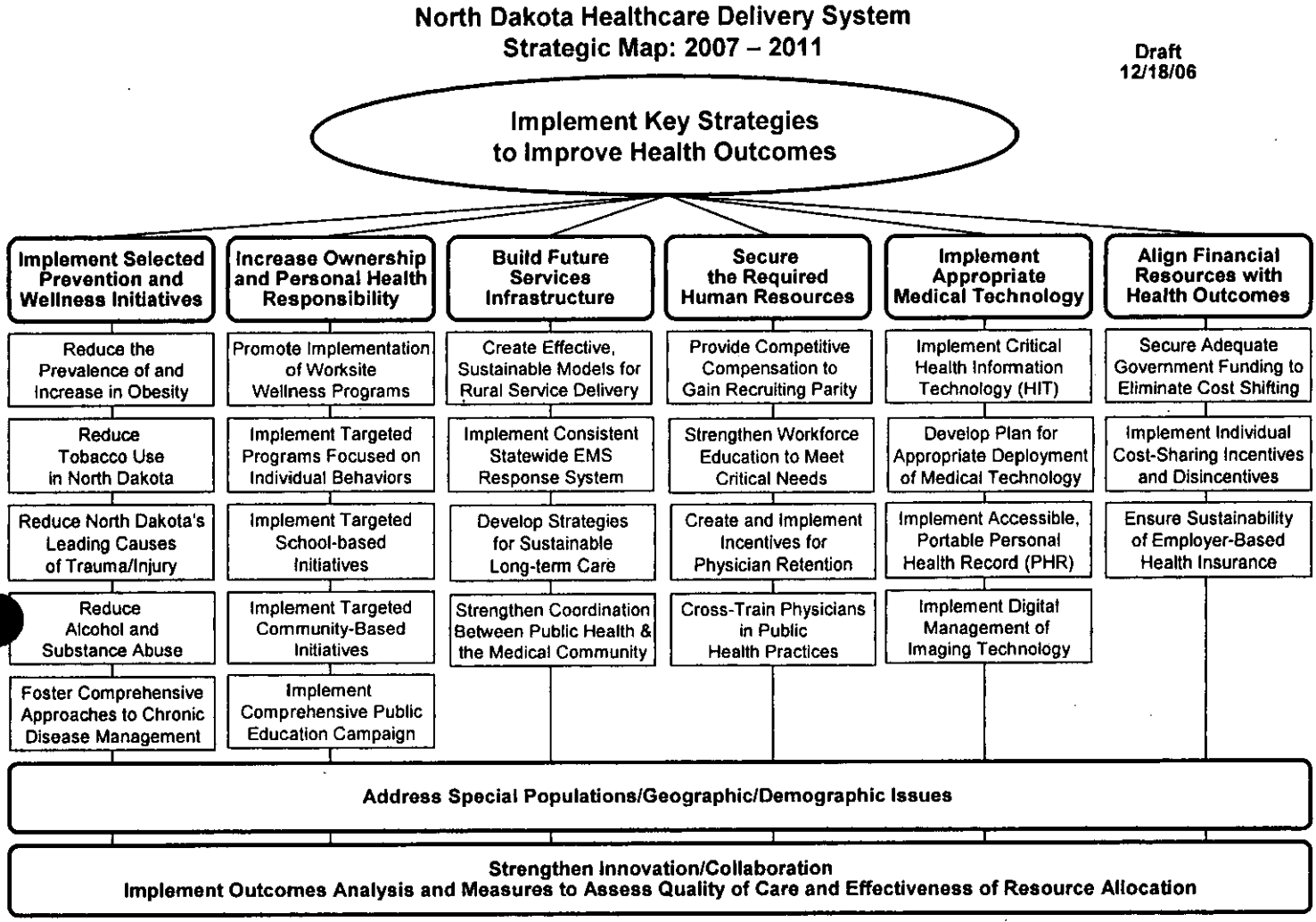
This vision will become a reality because:

- Our citizens—as individuals, groups and communities—embrace personal responsibility for their health and practice healthy lifestyles.
- Systematic approaches to prevention and wellness are supported by North Dakota's culture, policies, and institutions.
- Our healthcare system is structured and supported to provide access for all North Dakotans to appropriate, high quality, patient-centered healthcare in response to disease and injury.

This vision will be accomplished through a series of initiatives between 2007 and 2011 designed to ensure that our comprehensive and coordinated approach to health:

- Continually improves North Dakotan's health outcomes
- Integrates prevention, acute, and long-term care
- Provides timely access to quality emergency and trauma care
- Fosters the effective use of evidence-based and/or consensus-based practices with positive incentives for improving value and supporting the delivery of safe, high quality care
- Provides incentives to encourage living healthy lifestyles
- Encourages advance healthcare planning
- Addresses both individual and population needs
- Provides affordable access to all through a public and private system of health insurance that delivers universal coverage for essential healthcare needs
- Integrates effective use of new medical technology and an electronic health infrastructure
- Is flexible and innovative
- Is supported by an adequate workforce of health professionals to meet the needs of all North Dakotans
- Is fairly and adequately funded to meet the resource needs of public health and healthcare facilities and professionals
- Continues to recognize our traditional values of medicine in ensuring the independent judgment of healthcare professionals in their relationship with patients, medical ethics and professionalism
- Is sustainable over the long term

STRATEGIC MAP: 2007 – 2011



OTHER PRIORITIES

In addition to the strategic priorities and objectives outlined on the above Strategic Map, the following priorities also surfaced during the Committee's deliberations:

- Immunization
- Infectious disease, including STDs (sexually transmitted diseases)
- Toxic agents
- Prenatal and early childhood
- Mental health
- Legislative activities regarding seatbelt and helmet use and other high risk practices
- The aging physical plants of healthcare institutions
- Tertiary referral systems
- Pharmacy

- In-depth, statewide study of consumers
- Statewide wellness resource center
- Availability and use of in-state tertiary care
- Mental health workforce needs
- Tele-pharmacy
- Telemetry – in-home for special needs populations
- Internet sites endorsed by the state health department
- Preventive services investment plan
- Tax incentives for long-term care insurance/financing
- Review/analysis of dis-integration of healthcare services
- Mechanisms to address issues of the uninsured

The above priorities will be addressed in two ways:

- As projects initiated outside the Planning Committee process.
- As initiatives that will be carried out from 2012 – 2020.

House Human Services Committee Hearings

Tuesday, March 6, 2007

Good morning Madam Chair and members of the House Human Services Committee. Thank you for this opportunity to speak in support of Senate Bill No. 2303.

My name is Lynette Dickson; I am a Project Director at the Center for Rural Health, University of North Dakota and have had the pleasure of serving as the coordinator for the "ND Health Information Technology (HIT) Steering Committee".

I would like to provide you with a brief background of how the existing committee began. In April, 2006 the first **ND HIT Summit** was held. Based on information presented at the Summit, it was clear that numerous states are moving forward with statewide HIT initiatives in order to increase the efficiency of health care being delivered as well as to improve quality of care. According to the Institute of Medicine of the National Academies, information and communication technology is a powerful tool to help transform the American health system to the more desirable mode of care which is patient centered. To ensure that North Dakota not lose ground, a group of individuals formed the **ND HIT Steering Committee.** The eighteen committee members, represent a spectrum of stakeholders who recognize the urgency and share a commitment to helping our state develop, adopt, and use technology to improve the quality, safety and efficiency of health care for North Dakota residents. A list of the Steering Committee members is included with the documents provided.

The federal government has provided significant leadership in advancing the HIT agenda, however there is an enormous amount of important work to be done on the state and local level. According to the 2006 Ehealth Initiatives' annual survey, 35 states are planning or have already initiated HIT efforts. Our committee has been in contact with states that have surged ahead with successful approaches, such as Minnesota, Washington, Arizona and Rhode Island, to name a few. The focus of the committee has been to familiarize ourselves with the work being done in other states in order to glean lessons which can be applied in our state. For example, once a statewide committee/task force or advisory group has been formed the next step has consistently been to conduct a statewide assessment to determine such things as: the current adoption and utilization of technology, as well as the gaps, across a range of health care entities; the readiness of health care entities to adopt technology in their facilities; the challenges for facilities; the capacity of the state infrastructure; and assessment of the state standards for information exchange. This information is then used to inform recommendations and strategies for the state to promote the adoption of technology in a thoughtful yet progressive manner. A list of key national and state HIT/HIE activities is included in the documents provided.

Considering the size of North Dakota we are well positioned to make real strides in this area as long as we take action now and don't fall further behind in the HIT arena. The formation of this committee is the first step toward progress. To date, this effort has occurred through the commitment of members volunteering their time in order to keep state activity moving forward. A list of activities for the past year is provided. However, as with other states, we need a focused effort in our state that supports the further development of this infrastructure. Following effective strategies used in other states and in order to get the necessary work done in North

Dakota, we are requesting support for the essential work of a committee and respectfully request your consideration to restore the funding to the original $500,000 to also support grants for collaborative HIT planning and/or implementation pilot projects. A brief one page document is provided with the intent and deliverables of this Bill.

Without developing and implementing an active plan to incorporate Health Information Technology as part of our state's health care infrastructure, North Dakotans are at risk of being left behind as the nation moves forward with an electronic health care delivery system. Because of the efficiency, accuracy and availability of information, most of us wouldn't go to a bank that uses paper and pencil for transactions. Increasingly, we need to recognize -- as so many other states already do -- the importance of harnessing information technology for health care in the same way for many different reasons.

For example, as health care providers choose to practice in our state, the next generation is currently looking for places that have all the available tools-including health information technology essential to delivering high quality, efficient care. Health care consumers will be interested in and expected to play active roles in their health decisions. Ready access to their health information will be important to that active participation. Today we have individuals and organizations in the state who are committed to helping move this information technology agenda forward in order to transform and improve the way health care is delivered. Going forward, partnership and support from the state is an essential component of this effort and this bill helps to accomplish that. It is not a question as to "if" technology will be adopted in our health care system, it is a matter of when. For this reason it is the intent of the Steering Committee to work collectively and thoughtfully to address this.

On behalf of the Steering Committee I would like to thank, Representative Price and Senator Lee for recognizing the critical importance of supporting the state moving forward on building health information technology infrastructure and for having the foresight to sponsor this Bill.

This concludes my comments; I welcome any questions at this time.